



VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

February 21, 2017

Ms.. Lucia Leber, Manager
The Residence At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Ms. Leber:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on January 31, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota, RN".

Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/31/2017
NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An onsite investigation of three entity self-reports and two complaints was conducted by the Division of Licensing & Protection on 1/30/2017. Regulatory deficiencies were issued related specifically to one complaint. There were no findings related to the other investigations.	R100		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the facility failed to assure that nursing services were provided to Resident #1 (R#1) according to needs identified in the resident plan of care. Findings include: Per the resident plan of care (Service Plan), it calls for staff to "Assist resident as needed to assure safe transfer with 2 person assist and gait belt." On 1/13/17, R#1 was brought into the bathroom by one direct caregiver and a transfer to the toilet was attempted. During the attempted transfer the resident and caregiver both fell to the floor. The resident complained of pain in his/her left hip immediately after the fall according to reports. The resident was on Hospice at the time of the fall. A decision was made not to transfer	R126	The associate that performed the transfer is no longer an associate at the community. Resident care staff have been re-educated to performing tasks as described on the plan of care/assignments. Care plans will be reviewed with caregivers on an ongoing basis and at associate meetings. Associates found to not to follow care plans will be counselled and/or subject to corrective action. Resident Care is monitored by observation by supervisor staff, review of incidents that occur on the premises and reporting by staff.	3/1/17 3/8/17*

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6688

CT5811

TITLE

(X6) DATE

2/14/17

Paula Perley RN

Resident Care Director

If continuation sheet 1 of 3

* Note: Per email from P. Perley, completion dates changed to 3/8/17. Pncturn
 R136 - R266 POC's accepted 2/21/17 RTremblay RN/PnL

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2017
NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R126	<p>Continued From page 1</p> <p>him/her to the hospital and to provide comfort care at the facility.</p> <p>At 10:45 am the Executive Director (ED) and the Residential Care Director (RCD) confirmed that this resident was care planned for a two person transfer and that the transfer which resulted in the injury was attempted by one care giver.</p>	R126		
R224 SS=G	<p>VI. RESIDENTS' RIGHTS</p> <p>6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and staff interview the facility failed to assure that neglect did not occur for R#1 when staff failed to provide services according to the resident's identified needs. Findings include:</p> <p>Per the resident plan of care (Service Plan), it calls for staff to "Assist resident as needed to assure safe transfer with 2 person assist and gait belt." On 1/13/17; R#1 was brought into the bathroom by one direct caregiver and a transfer to the toilet was attempted. During the attempted transfer the resident and caregiver both fell to the floor. The resident complained of pain in his/her left hip immediately after the fall according to reports. The resident was on Hospice at the time of the fall. A decision was made not to transfer him/her to the hospital and to provide comfort care at the facility.</p> <p>At 10:45 am the Executive Director (ED) and the</p>	R224	<p>R224</p> <p>The associate that performed the transfer is no longer an associate at the community. Resident care staff have been re-educated to performing tasks as described on the plan of care/assignments. A mandatory Associate meeting is scheduled for March 1, 2017. Resident Rights and Abuse and Neglect Policies will be reviewed at this meeting. Care plans will be reviewed with caregivers on an ongoing basis and at associate meetings. Associates found to not to follow care plans will be counselled and/or subject to corrective action. Resident Care is monitored by observation by supervisor staff, review of incidents that occur on the premises and reporting by staff.</p>	<p>3/1/17 3/6/17*</p>

Division of Licensing and Protection

STATE FORM

689

CT5811

If continuation sheet 2 of 3

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/31/2017
NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT OTTER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 350 LODGE ROAD MIDDLEBURY, VT 05753		
(X4) ID PREFIX, TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R224	Continued From page 2 Residential Care Director (RCD) confirmed that this resident was care planned for a two person transfer and that the transfer which resulted in the injury was attempted by one care giver.	R224		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to assure a safe environment for R#1 related to a poorly fitting mattress. Findings include: Per observation on 1/31/17, R#1, who is on Hospice, has a hospital bed provided by the Hospice agency. The bed is observed to have bilateral side rails and a mattress overlay. There is a 5" gap between the headboard of the bed and the mattress noted. The Maintenance Director, present at the time of the observation, confirmed that the gap was unsafe and that he had been unaware that there was a gap. In an interview at 12:10 pm the RCD stated that the facility had received a memo from the Division of Licensing & Protection regarding siderail safety. S/he additionally stated that the facility did not own the bed and thus the facility staff did not do assessments of the equipment.	R266	R266 The company that owns the hospital bed was contacted immediately and the mattress was changed to an extra long mattress. Any hospital beds provided by this company to the community will have extra-long mattresses. In the event a hospital bed is delivered to the community, Nursing will ensure that an extra long mattress is provided and there is not a gap between the head board and footboard.	2/2/17

Division of Licensing and Protection

STATE FORM

8804

CT5811

If continuation sheet 3 of 3